

August 3, 2004

MDR Tracking #: M2-04-1579-01
IRO #: 5284

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor who is board certified in Anesthesiology and Pain Management. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 40 year old male who has a diagnosis of lumbosacral neuritis. He has low back pain radiating to both legs, which has not been helped with conservative therapy. This pain began after an accident at work on ___. The patient was repairing a truck when the hood of the truck fell down on him. He tried to lift it up and felt immediate pain in his low back. Other pertinent history includes a lumbar laminectomy in 1991 after which he did fairly well. He did have a recurrence of pain at one point but that resolved. At the time of this accident, the patient was fully employed working on trucks, doing manual labor. Because of his severe pain, he has been unable to work.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of chronic pain management program.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer states that 15 visits of a chronic pain management program are medically necessary. This patient has had well-documented symptoms of depression, which is reactive to the chronic pain from his work accident on _____. Other therapies have not helped, so at this point, he is in need of this chronic pain management program, which will help him in transition from being fully active and having no pain to a situation where he may have continual chronic pain and have to adapt to that. He should be involved in this program in order to transition from having no pain and having activity to a situation where he may have some pain on a chronic basis.

_____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. _____ has made no determinations regarding benefits available under the injured employee's policy. _____ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of _____, I certify that there is no known conflict between the reviewer, _____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

Sincerely,

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 4th day of August 2004